How to achieve quality prescribing on a budget

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When it comes to prescribing, primary care groups may find themselves caught between a rock and a hard place. They have been given the apparently conflicting, dual tasks of managing local drug costs and quality. To achieve the first, each PCG has been set a cash-limited, unified budget, which includes an element for prescribing, and to achieve the second, a range of initiatives including Health Improvement Programmes and the National Service Frameworks has been introduced in a bid to improve the quality of prescribing and other services offered in primary care

Limiting expenditure

PCGs will therefore have to find a means of simultaneously limiting their total drug costs while improving the quality of prescribing in local practices, but many groups will find it difficult, if not impossible, to control spending and improve quality at the same time.

To limit total expenditure sacrifices may have to be male either in the effectiveness or appropriateness of the medicines patients are prescribed. For example, the limited size of a PCG budget may mean that not all patients who should receive statins can do so. Therefore, when allocations are made to individual practices, PCGs may be unable to afford the budget increases that the desired quality improvements require.

Traditionally, prescribing in general practice has been seen an individual act performed by an individual practitioner for an individual patient. Until recently, attempts to improve the quality of prescribing have been aimed primarily at improving the information and training received by individual doctors, but the introduction of PCGs may challenge the traditional model.

Indeed, the pressure to simultaneously control costs and quality suggests that prescribing will become a governance issue of concern to both PCGs and practices, and not solely to individual practitioners. However, the trend for greater control may not be welcomed by all GPs.

One approach to improving prescribing behaviour among GPs is 'management by objectives'. Using this approach, each PCG should set and agree objectives for prescribing with local practices. For example, it may be agreed that savings generated through therapeutic substitution are used to improve prescribing for coronary heart disease patients.

Next, the agreed objectives for prescribing should be disseminated to all local practices. In turn, all GPs should be asked to discuss and agree the activities they must undertake so that the desired aims are realised.

To be successful, the 'management by objectives' approach requires that the performance of individual practices and GPs is regularly measured against locally agreed goals, and that individual prescribing strategies are modified if either practice or PCG objectives are unlikely to be secured.

The success or otherwise of this approach may depend on the circumstances faced by individual practices and PCGs. For example, evidence suggests that that practices are more able to control their drug costs if significant savings can be generated through increased generic prescribing.

But with the high levels of generic substitution already achieved in many areas, coupled with recent increases in the price of non-proprietary drugs, the ability of some PCGs to control local prescribing expenditure by this means may be severely limited.

Patient needs

As a result, PCGs may find quality goals- for example, increased prescribing of statins to patients at risk of may be difficult to achieve they cannot generate the funds necessary for such improvements in quality while still meeting all patient needs.

Thus, success at managing a unified budget may depend on a PCG's ability to develop an effective system for co ordinating local prescribing behaviour.

To be successful, the system should be linked to locally agreed prescribing objectives and be able to influence how local practitioners prescribe. Success will also depend on several factors, including the coordination of PCG prescribing committee decisions with those of other stakeholders such as hospital drug and therapeutic committees, the introduction of an effective mechanism for promoting peer support and review, and the availability of sufficient resources to enable all GPs to participate fully in the governance process.

In total, the successful management of prescribing objectives requires the design. construction and operation of effective governance system, as well as the support and participation of a significant number of local prescribers.

As unified budgets are unlikely to be sufficient to meet all patient needs for high qual ity and appropriate drugs, PCGs will have to devise some mechanism for fairly distributing the sums they receive.

Transparent system

As a gain in funding by some practices will result in losses by others, PCGs should develop a fair and transparent system for making their budget allocation decisions.

As part of this process, the allocation process should be "open in the sense that both practices and individual GPS are able to question the means by which their budgets were set. To achieve fairness and transparency, it will also be necessary to give individual patients or patient groups the ability to question and check PCG prescribing objectives and funding decisions.

When developing a local formulary the principles of fairness, transparency and accountability should also be applied. Indeed, PCG boards should be limited by these principles whenever they take management decisions that affect local practices or patients.

If these principles are not followed, they may leave themselves open to the criticism that their objectives or resource allocation decisions are self interested, or that they are unfair to parties unable to participate in the decision-making process.

Even if they establish a fair, transparent and accountable system for decision-making. some GPs may see PCGs as impinging upon their clinical and financial autonomy. In response, some may attempt to protect their personal interests by becoming board members or working closely with PCG decision-makers. Others may suffer, as they either disagree with local PCG policies or lack the time or ability necessary to represent themselves or their interests.

The effect this has on individual patients may depend upon the influence their GP has on PCG decisions and the degree to which they are willing to subsume their interests for the good of the local population as a whole.

In other words, a form of 'two-tierism' may arise in which patients of doctors working with or for their local PCGs may gain at the expense of those whose practitioners are not. In response, some patients may find it necessary to form groups with other patients to represent their joint interests to their local PCG boards.

Indeed, closer collaboration among practitioners may lead to greater co-ordination among patients, if their needs are not being met.

Balanced demands

Given their structure, PCGs are currently acting as intermediaries between health authorities and local practices Given this role, board members have to balance the demands placed upon them by the Government with those placed upon them by their peers. They may have to decide whether to act primarily for the government by ensuring that NHS guidelines are met within the cash-limited sum that they receive, or to work as advocates for their peers by attempting to secure greater funding for their patients.

In practice, it is likely that most PCGs will settle somewhere between these two positions by attempting to control local quality and costs, whilst working to secure larger budget allocations each year Despite their efforts, it is likely that Government efforts to cash-limit PCG budgets will constrain the ability of practitioners to prescribe high quality and appropriate drugs for their patients.